1250 SERVICES PROVIDED ON AN INPATIENT AND OUTPATIENT BASIS

A. BEHAVIORAL HEALTH SERVICES AND SETTINGS

Description. AHCCCS covers behavioral health services within certain limitations for ALTCS members. ALTCS members may receive medically necessary behavioral health services (mental health and/or substance abuse services) through an ALTCS Contractor.

Amount, Duration and Scope. Behavioral health services may be provided to members residing in their own home, in an institutional setting specified in Policy 1210, or a HCB approved alternative residential setting specified in Policy 1230 of this Chapter.

Refer to the section on behavioral health services included in Chapter 300, Policy 310, for a listing of covered services, Appendix G of this Manual for a complete description of the services and Chapter 1600 for the case management related behavioral health standard.

B. RESERVED

The ALTCS Adult Dental Benefit is suspended effective 6/30/08.

C. HOSPICE SERVICES AND SETTINGS

Description. AHCCCS covers hospice services provided to ALTCS members who meet medical criteria/requirements for hospice services. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual and social stresses which are experienced during the final stages of illness and during dying and bereavement. These services may be provided in the member's own home, a home and community based (HCB) approved alternative residential setting as specified in Policy 1230 of this Chapter, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

1. Hospital

2. Nursing care institution, and

3. Free standing hospice.

Providers of hospice care must be Medicare certified and licensed by the Arizona Department of Health Services (ADHS) and have a signed AHCCCS provider agreement. Refer to Chapter 300 of this Manual for rules governing licensure for these facilities.

Amount, Duration and Scope. Hospice services are available only for ALTCS members who have been certified by a physician as being terminally ill and who elect to receive hospice care. If the member is receiving hospice services under Medicaid Title XIX, the services must be ordered by the member's primary care provider (PCP) and authorized by the case manager though the member's service plan. If the member is receiving hospice services under Medicare, the services do not require case manager authorization; however, the case manager remains responsible for monitoring the member's care to ensure the receipt of needed services.

Hospice services may be provided on an inpatient basis when the member's condition is such that care can no longer be rendered in the member's own home or an approved HCB alternative residential setting. Hospice home care services may be provided as routine home care or, when medically necessary, on a continuous home care basis.

Regardless of whether the member is Medicare-primary, or ALTCS-only, the case manager, the member's PCP and hospice staff are responsible for making a coordinated determination regarding the appropriate level of care for the member. If a dispute arises regarding the level of care that is medically necessary for the member, the final determination must be made by the member's PCP.

Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits (i.e., home health aide, personal care and homemaker services) will not be covered. Attendant care is not considered a duplicative service.

If the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor may report such cases to ADHS as the hospice licensing agency in Arizona.

State licensure standards for hospice care require providers to include skilled nursing, respite and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services and inpatient services available as necessary to meet the member's needs. The following components are included in hospice service reimbursement when provided in approved settings:

1. Bereavement services provided by the hospice which include social and emotional support offered to the member's family both before and up to twelve months following the death of that member. There is no additional cost to ALTCS for bereavement services provided to the family after the death of the member.

2. Continuous home care (as specified in the definition of hospice services included in Chapter 300 of this Manual) which may be provided only during a period of crisis.

3. Dietary services which include a nutritional evaluation and dietary counseling when necessary.

4. Home health aide services.

5. Homemaker services.

6. Nursing services provided by or under the supervision of a registered nurse.

7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology or a related field and who is appropriately licensed or certified.

8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting indicated above.

9. Routine home care, as specified in the definition of hospice services included in Chapter 300 of this Manual.

10. Social services provided by a qualified social worker.

11. Therapies which include physical, occupational, respiratory, speech, music and recreational therapy.

12. Twenty-four hour on-call availability to provide services such as reassurance, information and referral for members and their families or caretakers.

13. Volunteer services provided by individuals who are specially trained in hospice care and who are supervised by a designated hospice employee. Pursuant to Title 42 of the Code of Federal Regulations, Section 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services.

14. Medical supplies, appliances and equipment, including pharmaceuticals, which are used in relation to the palliation or management of the member's terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

The unit of service is per diem based. Services are provided as routine home care, continuous home care, inpatient respite care or general inpatient care.

D. MEDICAL/ACUTE CARE SERVICES

Description. Medical/acute care services are covered as specified in Chapter 300, Policy 310. Medical/acute care services provided to ALTCS members are the same as those provided to members enrolled in the acute care program, with the exception of therapies described in this Chapter.

Amount, Duration and Scope. These services require orders from the member's primary care provider or attending physician, and in some cases, authorization from the member's case manager. Refer to Exhibit 1240-3 in this Chapter for information regarding authorization sources for acute/medical care services and home and community based services (HCBS).

Medical/acute care services may be provided to ALTCS members residing in their own home, institutional setting or any ALTCS approved alternative HCB residential setting, and in conjunction with any HCBS.

E. RESPITE CARE

Description. AHCCCS covers respite care (short-term or continuous) for ALTCS members residing in their own home. Services are provided as a non-routine interval of rest and/or relief to a family member or other unpaid persons caring for the ALTCS member, and to improve the emotional and mental well-being of the member.

Amount, Duration and Scope. The services may be provided by a respite provider coming to the member's residence, as well as by admitting the member to a licensed institutional facility or an approved home and community based (HCB) alternative residential setting for the respite period.

Short-term respite is defined as 12 hours or less, either in the member's residence or in another facility. The unit of service for short-term respite is 15 minutes. Continuous respite is available to members in need of temporary separation from their family or living environment for time periods of 13 hours or more; the unit of service is per diem. The combined total of short-term and/or continuous respite care cannot exceed 30 days or 720 hours per contract year (October 1st through September 30th). The 720 hours is inclusive of behavioral health respite care.

Respite care may only be delivered as specified and authorized by the member's case manager in the member's service plan. If a family member or significant other routinely needs a block of time for relief, attendant care may be considered as an alternative to respite care. Respite services include, but are not limited to:

1. Supervision of the member for the period of time authorized by the case manager

2. Provision of services during the respite period which are within the respite provider's scope of practice, are authorized by the member's case manager and are included in the member's service plan, and

3. Providing activities and services to meet the social, emotional, and physical needs of the member during the respite period.

If respite care is provided by one of the facilities listed below, that facility must be licensed by the Arizona Department of Health Services and Medicare certified when applicable.

1. Nursing care institutions

2. Adult day health care providers

3. Approved HCB alternative residential facilities included in Policy 1230 of this Chapter, and

4. Home health agencies (HHA).

Individuals who provide respite care must hold a current certification in cardiopulmonary resuscitation and first aid, have appropriate skills and training to meet the needs of each member assigned to them and submit three letters of reference. All references, skills and training must be verified and documented in the employee's personnel file when working for an agency.

If respite care is provided in an institutional setting or a HCB approved alternative residential setting, other ALTCS services may be provided, as allowed in the specific setting and if included in the member's individualized care plan. Examples are as follows:

1. If the member resides in his/her own home and is authorized to receive home health skilled nursing services but is receiving respite care from a nursing facility (NF), the facility may provide nursing services but the services will be included in their per diem.

2. If the member also requires home health therapy services, the NF may provide the services, but because they are not part of the NF per diem, the services should be billed/reported in addition to the per diem day. Refer to Policy 1210 of this Chapter for additional information regarding institutional services and Policy 1240 of this Chapter for information related to HCBS.

If respite care is provided in the member's own home, all HCB services included in the member's service plan may be provided in conjunction with respite care. Examples are as follows:

1. If the member is receiving personal care services, he/she may continue to receive this service in conjunction with the respite care. However, if the service is included in the scope of practice of the respite care provider, it is included as a part of the unit rate for respite care and is not billed separately.

2. If the member requires home health skilled nursing services, the services may be provided in conjunction with respite care, but are billed/reported separately by the HHA.

When respite care is determined necessary for ventilator dependent members in their own home, or a HCB approved alternative residential setting, it must be provided at the member's level of medical need. Respite care may be provided by the following:

1. Private duty skilled nursing services, if available and determined to be medically necessary

2. If skilled nursing personnel are unavailable to provide respite care, services may be provided by a respiratory therapist when both of the following conditions are met:

    a. The member's primary care provider must approve/order the care by the respiratory therapist, and

    b. The member's care requirements must fall within the scope of practice for the licensed respiratory therapist as defined in A.R.S. §32-3501 and orientation to the care needs unique to the member must be provided by the usual caregiver or the member.

F. THERAPIES

Description. AHCCCS covers occupational, physical and speech therapy services, as well as audiology services, that are ordered by a primary care provider (PCP), approved by the AHCCCS Division of Fee for Service Management or the Managed Care Contractor, and provided by or under the direct supervision of a licensed therapist as noted and applicable in this section.

Members residing in their own home or a HCB approved alternative residential setting may receive physical, occupational and speech therapies through a licensed Medicare-certified home health agency (HHA) or by a qualified licensed physical, occupational or speech therapist in independent practice, as applicable.

Services require a primary care provider (PCP) or attending physician's order and must be included in the member's individualized care plan. The care plan must be reviewed at least every 62 days (bimonthly) by the member's PCP or attending physician when services are received in home or in an approved alternative setting.

Amount, Duration and Scope. Therapy services must be prescribed by the member's primary care provider (PCP) or attending physician as a medically necessary treatment to develop, improve or restore functions/skills which have not been attained, are underdeveloped or have been impaired, reduced or permanently lost due to illness or injury. Therapy services related to activities for the general good and welfare of members, activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes and are not covered under ALTCS.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the member's physician for reasonable and necessary treatment of a member's illness or injury, habilitation or rehabilitation. If necessary, the physician should consult with a qualified therapist.

For purposes of this Policy, reasonable and necessary means:

1. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the member's condition.

2. Based on the assessment made by the PCP/attending physician of the member's restoration potential, there must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required for a specific injury or illness, and

3. The amount, frequency and duration of the services must be reasonable.

Developmental/Restorative Therapy

A therapy service must be reasonable and necessary to the functional development, and/or treatment of the member's illness or injury. If the member's expected potential for improving or restoring functional level is insignificant in relationship to the type and number of therapy services required to achieve such potential the therapy would not be covered for other than a maintenance program as described below. If at any point in the development of skills, or the treatment of an illness or injury, it is determined that the therapy expectations will not materialize, the services will no longer be considered reasonable and necessary.

Maintenance Program

If the developmental or restorative potential is evaluated as insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified therapist may be required to assess and establish the maintenance program to achieve the treatment goals of the ordering PCP or attending physician. After the member's condition has been assessed, and the member's caregiver has been instructed/trained in the established maintenance program components, the services of the qualified therapist are no longer covered except for reassessments and treatment plan revisions. Refer to Chapter 300 for additional information regarding therapy services.

Physical Therapy

Description. AHCCCS covers physical therapy (PT) services for ALTCS members. Services provide treatment to develop, restore, maintain or improve muscle tone and joint mobility and to develop or improve the physical/functional capabilities of members.

Amount, Duration and Scope. Physical therapy services must be rendered by a qualified physical therapist licensed by the Arizona Physical Therapy Board of Examiners, or a physical therapy assistant (under the supervision of the PT, according to 4 A.A.C. 24, Article 3) certified by the Arizona Physical Therapy Board of Examiners. Therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal regulations. Refer to Chapter 100 of this Manual for a listing of licensure rule citations pertaining to physical therapists and PT assistants.

One unit of service (15 minute increments) is equal to an authorized treatment service and includes, but is not limited to:

1. Administering and interpreting tests and measurements performed within the scope of the practice of PT as an aid to the member's treatment

2. The administration, evaluation and modification of treatment methodologies and instruction, and

3. The provision of instruction or education, consultation and other advisory services.

Occupational Therapy

Description. AHCCCS covers occupational therapy for ALTCS members to achieve their highest level of functioning, maximize independence, prevent disability and maintain health. Services may be provided to members who are functionally limited due to physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, socioeconomic and cultural differences or the aging process. The services include activities such as evaluation, treatment and consultation.

Amount, Duration and Scope. Occupational therapy (OT) services must be provided by a qualified occupational therapist licensed by the Arizona Board of Occupational Therapy Examiners or a certified OT assistant (under the supervision of the OT, according to 4 A.A.C. 43, Article 4) licensed by the Arizona Board of Occupational Therapy Examiners. Therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal regulations.

One unit of service (15 minute increments) is equal to an authorized treatment service and includes, but is not limited to:

1. Evaluation of, and training in, activities of daily living, social skills, work and related activities

2. Development or enhancement of functional achievement, pre-vocational skills and work capabilities through the use of therapeutic, kinetic, functional, manual and creative activities or exercises

3. Assessment and adaptation of the member's living and work environments for individuals with disabilities, handicaps and those at risk for dysfunction, and

4. Other duties or tasks included in the therapist's care plan for the member that are necessary to assist the member in gaining or maintaining his/her highest level of self sufficiency.

Speech Therapy

Description. AHCCCS covers speech therapy (ST) services for ALTCS members who need to develop, increase or improve communication effectiveness and/or their oral functioning, including swallowing. ST services include evaluation, program recommendation for treatment and/or training in receptive and expressive language, voice, articulation, fluency and aural habilitation and rehabilitation, and medical issues dealing with swallowing.

Amount, Duration and Scope. ST must be provided by a qualified certified speech-language pathologist licensed by the Arizona Department of Health Services (ADHS) or a speech-language pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist and complete the fellowship within 2 years or the registration is terminated. Therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal regulations.

One unit of service is equal to an authorized treatment service and is limited to one unit per day. Covered speech-language pathology services consist of evaluation and therapy.

Services include, but are not limited to:

1. Services concerned with diagnosis or evaluation which includes language assessment tests to ascertain the type, casual factor(s) and severity of the speech language disorder, and

2. Therapeutic services for common medical conditions or disorders with resulting communication deficits that necessitate active developmental or restorative therapy.

Services include, but are not limited to:

1. Conducting a current assessment and/or a review of previously administered speech/language assessments in order to develop an individual speech/language program

2. Developing and implementing a speech/language program that meets the member's needs and is included in therapist's care plan for the member

3. Evaluating the effectiveness of the program on a regular basis, modifying the program as required, and notifying the case manager of any changes,

4. Training appropriate individuals involved with the member to perform necessary therapeutic activities to implement the speech-language program, and

5. Swallowing evaluation and training.

Some members require services involving non-diagnostic, non-therapeutic, routine, repetitive and reinforced procedures or services for their general good and welfare, such as practicing word drills. These services are not covered since they do not require a qualified speech-language pathologist.

Audiology

Description. Audiology is an AHCCCS covered service, within certain limitations, to evaluate hearing loss and rehabilitate members with hearing loss through other than medical/surgical means.

Amount, Duration and Scope. AHCCCS covers medically necessary audiology services to evaluate hearing loss for ALTCS members on both an inpatient and outpatient basis.

Beginning June 28, 2004, audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the Federal requirements specified under 42 CFR 440.110. Out-of-state audiologists must meet the Federal requirements.

The Federal requirements mandate that the audiologist must have a Master's or Doctoral degree in audiology and meet one of the following conditions:

1. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

2. Have successfully completed a minimum of 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised experience under the supervision of a qualified Master's or Doctoral-level audiologist), performed not less than nine months of supervised full-time audiology services after obtaining a Master's or Doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

Hearing aids provided as a part of audiology services are covered only for members under the age of 21 who are receiving EPSDT services or are enrolled in KidsCare. Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license issued by ADHS.

Refer to Chapter 400 for additional information on services provided to persons under the age of 21 and the EPSDT program.

G. RESPIRATORY THERAPY

Description. AHCCCS/ALTCS covers respiratory care services prescribed by a primary care provider (PCP) or attending physician to restore, maintain or improve respiratory functioning. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures; observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols.

Amount, Duration and Scope. Services must be provided by a qualified respiratory practitioner under A.R.S. §32-3501 (respiratory therapist or respiratory therapy technician) licensed by the Arizona Board of Respiratory Care Examiners.

Additionally, a licensed respiratory practitioner participates with the case manager to develop the member's service plan, develop and teach therapy objectives and/or techniques to be implemented by family members or the staff of the institution or HCB alternative residential setting where the member resides, and perform other duties and tasks which are included in the therapist's care plan for the member and are designed to restore, maintain or improve respiratory function.

Services may be provided to members in an Arizona Department of Health Services licensed institutional setting as specified in Policy 1210 of this Chapter. ALTCS members residing in their own home or a HCB approved alternative residential setting may also receive respiratory care provided through a licensed, Medicare certified home health agency or by a qualified licensed respiratory therapist in private practice.

Services require a physician's order and must be included in the member's individualized care plan. The care plan must be reviewed at least every 62 days (bimonthly) by the member's primary care provider or attending physician.

One unit of service is equal to one authorized treatment, and limited to one procedure per day.

Note: If skilled nursing personnel are unavailable to provide ventilator dependent care services in the member's own home or HCB approved alternative residential setting, services may be provided by a licensed respiratory practitioner when both of the following conditions are met:

1. The member's PCP must approve/order the care by the respiratory therapist, and

2. The member's care requirements must fall within the scope of practice for the licensed respiratory therapist as defined in A.R.S. §32-3501 and orientation to the care needs unique to the member must be provided by the usual caregiver and/or the member.

Refer also to Chapter 300 for therapy descriptions.

1260 RESERVED

1270 RESERVED